Testimony for Senate Committee on Indian Affairs

Presented by Douglas Eby MD MPH FAAFP
SCF VP Medical Services

Representing: Southcentral Foundation – Alaska Native non-profit health corporate arm of Cook Inlet Region Incorporated located in Anchorage, Alaska.

Outline

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III. SCF Steps to Transform Health Services
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It is an honor to be able to address this committee on behalf of the Southcentral Foundation Board of Directors, the President/CEO – Ms. Katherine Gottlieb, the corporate vice presidents and the staff.

I come to you as a corporate vice president and a physician administrator privileged to work for a Native corporation, Southcentral Foundation (SCF), in the service of the Alaska Native peoples of Anchorage, Alaska. SCF has a long history of developing and providing innovative, community based health programs and we are proud to share with you some of what we have been able to do.

The past several years have been particularly challenging and exciting as Alaska Native leadership have completed the process of transferring all remaining Indian Health Service programs in Alaska to Native ownership and management. This includes the transfer of the largest Indian Health Service facility and medical system in the United States – the Alaska Native Medical Center. We have then proceeded to transform the system into one that is becoming one of the finest anywhere in the entire country.

II. Advantages of Local, Native Customer-Ownership

There are many reasons why the transfer of ownership and management of programs previously under the I.H.S. has been a good thing for health systems. Some of them include:

1. Customer ownership – health systems are best when in the hands of those for whom they provide services. Healthcare is a service industry. Service industries are best when closely attuned to the customer and there is no better way to assure this than by putting the system in the hands of the customer.

2. Native ownership – the services SCF offers are for Alaska Native clients. Services offered by a Native-owned system are naturally going to be more Native appropriate.

3. Private corporate ownership – the change from being Federally owned to being a private healthcare corporation has opened a lot of doors. SCF has been able to add millions of dollars to provide expanded services through grants and contracts previously unavailable to the Federally owned system.

4. Local ownership – being a self-contained, local corporation provides the opportunity to be locally focused and more rapidly responsive than was possible with a large government system centrally controlled from 5,000 miles away. Our ability to understand local dynamics and to partner with other local groups has expanded our ability to provide services.

5. The improvements with 'Compacting' – the flexibility afforded SCF by the compacting relationship where SCF has considerable freedom in controlling and reshaping systems to be more appropriate to the local situation has allowed considerable improvements in service delivery.

In the following pages we describe what we have done in developing new programs and transforming those we have taken over from the I.H.S. The most recent example is what we have done in the past two years to completely transform the services we took over from the Indian Health Service at the Alaska Native Medical Center (ANMC) in the spring of 1998.

We spend considerable time learning about cutting edge ideas transforming healthcare nationally. We then adopt the best practices we find nationally, put them together in new ways, and adapt them to our system. By adopting and adapting the best healthcare system practices nationally and combining that with the wisdom and the strength of the Native community we have created the best of all possible worlds and are convinced *we are creating something very special and very impressive.*

One example of what we have done is that in the past year we have helped nearly 30 thousand clients choose their own primary care provider for them and their family, made it possible to see that provider consistently over time, and have *access to that provider for*

whatever they want when they want it. It is now possible for these clients to call today and be seen by their provider today for whatever they need.

This system is also a *relationship-based system of care* where each visit builds on the previous one. Patients don't have to tell their whole story from the start over and over. It allows the primary care team and the client to get to underlying issues that really determine illness and health. These issues include such things as depression, substance use, violence, relationship difficulties, obesity, smoking, etc, etc. The opportunity to not just deal with the immediate crisis, but get to the real determinants of health and wellness finally exists.

Systems like this allow the provider, case manager, and client to get more real work accomplished every visit. Over time the patients' ability to do more for themselves and make their own healthcare decisions goes up. Patient satisfaction and provider satisfaction go up. Healthcare outcomes improve, ER visits go down, and hospital admissions decrease. Over time outpatient visits also go down. In other words efficiency improves while effectiveness improves and satisfaction of everyone goes up. It is possible to do. We are doing it.

We are also rapidly and effectively putting the health system *into Native hands* at all levels while developing highly capable Native leaders and increasing the availability of clinical staff by giving them better non-clinical support. In the past the I.H.S. system used doctors and nurses as the only managers in departments. We now have professional managers who are Alaska Native that we train in budget and personnel management in addition to all additional management skills. We allow the clinicians to return to predominantly clinical work while providing overall direction and we have added considerable business and personnel expertise to the clinical expertise already existing. *It is a change that has improved everything about how the system is managed while putting the system into Native hands and building highly capable Native leadership for the future.*

We have also taken all of our programs – developed and inherited – and made them into a planned, intentional system of care. Way too often healthcare consists of a bunch of loosely connected program 'islands' that create a lot of duplication of effort, poor hand-offs, and inefficient and ineffective care. We have outlawed 'islands', have instituted population based thinking and planning, and *have created a system of care that is centered around how it works best for the client and how the client wants it.*

Additionally we have taken the unique strengths of the Traditional Native way of doing things and added that to the predominantly allopathic medical system we inherited and developed. This includes the incorporation of Native ways and thoughts into our mainstream health systems. It includes the development of particularly Native programming that targets youth and adults in difficulties who need to rediscover strong roots and identity to move toward health. It has meant redesigning programs around the Native family and community. It has also meant investing heavily in helping all of our staff understand Native history, Native cultures, Native priorities, and Native ways.

We are convinced that publicly funded, well-managed healthcare systems in the hands of the customers are the most effective model for healthcare delivery provided there is effective and accountable management. Much of what is known as 'managed care' in the United States has resulted in conflicted incentives where the advantages of this approach are lost in the competing incentives of poorly designed systems. We believe we have demonstrated that when you align the incentives correctly and create the right combination of incentives, you can create truly impressive and effective healthcare delivery that produces amazing outcomes while improving efficiency and effectiveness.

The following pages list in brief, bullet form what we have done to transform our system. This is followed by a brief description of what else we intend to do if funding can be expanded.

III. SCF's Steps to Transforming a System of Healthcare:

At SCF we have undertaken a complete system transformation of what we inherited from the I.H.S. and incorporated it into what we developed ourselves. Changes have occurred in philosophy, structure, and direct services offered our customer-owners. The list below contains many of the elements that went into this system transformation and each is further defined in sections that follow.

1. *Mission driven organization*
2. *Senior Management alignment and support*
3. *Unwavering customer focus*
4. *Customer-owner solidification*
5. *Population based approach to system design*
6. *Team Management*
7. *Intentional, planned Native management development and implementation*
8. *Business oriented management development*
9. *Access to care*
10. *Relationship based Primary Care Provider system*
11. *Case Management*
12. *Integration of Departments – System of Care*
13. *HR processes redesign*
14. *Aligned incentives throughout the system*
15. *Central Budgeting and Planning*
16. *Intentional Planned processes*
17. *Alignment of Processes*
18. *Improvements in Clinical Quality*
19. *Facilities*
20. *Effective Budgeting for the long term*
21. *Long term thinking and planning*

22. Expanding rural ASU system of care
23. Continuum of Care
24. Development of partnerships and other sources of funding

1. Mission driven organization

- Mission, vision and key points everywhere – on walls, pens, shirts, mouse pads.
- Job Descriptions and evaluations based on these statements and values. For example, everyone in the organization – everyone – is evaluated on Team Contribution, Communication, and Professional Responsibility.
- The entire management structure and decision making process has been revamped.

2. Senior Management alignment and support

- The SCF Board, the CEO evaluation, the Board driven priorities, the corporate plans, etc. are all driven by the mission and key points. The Primary Care Plan being implemented was a product of customer, staff, management and Board input. It was approved and supported at all levels before implementation.
- The Board and President/CEO themselves continually and strongly support the Mission and Key Points.
- Communication, planning, and updates flow up and down the system continually in order to keep everyone aligned.

3. Unwavering customer focus

- ***Systems were changed dramatically to bring services to the patient rather than have the patient go to lots of different locations.***
- Continual feedback and accountability regarding patient/customer experience.
- Corporate wide expectation that things will go right.
- Unwavering passion from CEO regarding a high performing system and intolerance of second best.
- Active customer service team with many activities. Is a standing agenda item at every managers meeting.
- Current development of the Patient Resource Center.
- Development of Patient Advocate system in the hospital.
- Development of greeters.
- Development underway for short-term child support while adult receives care.

4. Customer-owner solidification

- Transition from Federal system to Native ownership and oversight complete
- Continual reminder to management and staff that the SCF Board ultimately controls the shape and priorities of the corporation.
- Placement of Native managers in every department in Medical Services is completed.

5. Population based approach to system design

- Departments in the Federal system of the past were basically employee centered. Work was defined as seeing those patients that managed to figure out the system well enough to get onto provider's schedules. There was created a constant tension between patient demand and employees 'protecting' themselves.
- ***All departments now told they must think about the entire population they have expertise to offer and how best to deliver services to that entire population.***
- Departments are encouraged to think system wide and find ways to support others doing some of the work and reserving to themselves those things that only they can do.
- Examples:
    1. Mental Health – Now thinks of the entire Anchorage population, and to some extent the ASU and the entire state. They are working with PCP's (Primary Care Providers) and case managers in other departments to build their capacity to handle basic mental health issues. They have assessed how the customer uses the system and are in the process of redesigning their processes to match customer use.
    2. Women's Health – They are working to create standardized care for women wherever they are seen – women's health, family medicine, urgent care center. They are focusing on standardizing and improving pregnancy care. They are working to develop ways to be more efficient and effective in their specialized areas of gynecology and gynecologic oncology.
    3. Pediatrics – Similar to Women's Heath. They are working at standardizing and building capacity for children no matter where they are seen. They are developing a center of excellence around fetal alcohol affected children. They are building relationship based, continuity oriented, same day access capable primary care.
    4. Family Medicine – Have created and implemented a relationship based, continuity oriented, case management empowered, same day access capable system for all adults in the ASU and all children who choose to use this system.

6. Team Management

- Every department of significant size has a management team
- The larger clinical departments have an outpatient clinic management team, an inpatient management team, and an overall physician medical director.
- Decisions are by consensus and are to have included input from all levels of the department and are to have included consideration of the patient/customer.
- Teams include clinicians and non-clinician professional managers.
- Our nursing leadership have been instrumental in driving the creation of a shared governance system of nursing input across the campus.
- The nursing shared governance process has created nursing councils that help standardize processes and align incentives.
- The new Medical Staff Bylaws at ANMC create the structure and system for more activist involvement by the medical staff in quality of care.

7. Intentional, planned Native management development and implementation

- A system of advancement is in place. One can advance from Clerk I to Clerk II to Support Coordinator to Clinic Coordinator to Health Systems Administrator (levels I, II, and III) to Vice President.
- ***Creation of Clinic Coordinators. These are office managers for most of the programs. These are, by definition, Alaska Native managers. They are mostly young, college graduate managers with little hands-on experience. Through an intentional, mentored process they develop into very capable, highly responsible office managers. These are now the day to day managers of the departments.***
- SCF has a well-developed program of support for those pursuing education and degrees. Time off of work is provided, support during pursuit of advanced degrees, and large amounts of non-degreed skill development is supported.

8. Business oriented management development

- In the past managers of departments were doctors and nurses plucked from the current department. With the addition of full time clinic coordinators there are business-oriented managers in every clinical location.
- Budgets are now developed with considerable department input. Budgets are then given to departments to manage.
- We are starting to see department management see their operations as a budget rather than a collection of FTE's. There is still a long way to go.
- We have worked to bring a higher priority to the revenue collections system.

9. Access to care

- Our patients want access to services – above all else.
- Our patients want access to their PCP. They don't want to have to tell their story over an over to new providers every time.
- At SCF we now have PCP's whose job it is to meet the needs of their panel of patients. Over 25,000 persons in the ASU have chosen a PCP (or had one assigned in the case of rural villages).
- ***The rule is 'do all of today's work today'. The only reason for a patient to not be seen today (for anything) is if the patient requests otherwise or it is a scheduled follow-up appointment. Same day access for anything the patient wants is the rule.***
- At present we are matching patients and PCP's in actual visits around 55-70% of the time (used to be 20-30%, national best practice is 65-75%) and every PCP's schedule is half-open at the beginning of the day.

10. Relationship based Primary Care Provider system

- Sustainable, significant lifestyle change and effective patient education only occur in longitudinal relationship based systems. We have created such a system.
- ***Every patient now sees their chosen PCP when they want to see them unless they are out of town. Every visit builds on the previous visit. This system allows the client and provider to get past the superficial issues to the underlying true determinants of illness and health.***

- The team of PCP, Case manager, floor nurse, patient and family is a critical component.
- Patient and family Self-Care is a cornerstone of this system.

11. Case Management

- There is now a strong body of evidence to show that good, pro-active case management is essential to effective care of chronically ill and medically fragile patients.
- ***There is strong evidence that hospitalizations go down, overall health care expenditures go down, quality of life goes up, patient satisfaction goes up, and provider satisfaction goes up in a case management oriented system.***
- SCF has integrated immunization money, diabetes money, and research grant money into the case management system. What has resulted is a one-to-one ratio of physicians and case managers.
- Case managers coordinate village care, follow-up care for patients who are seen, and proactive case management for those for whom it is appropriate.

12. Integration of Departments – System of Care

- The SCF Board and CEO have mandated an integrated system of care
- SCF management has adopted a 'no more islands' mantra
- The Federal system at ANMC ran the place a loose collection of independent, hardly accountable islands pretty much left to their own devices. SCF has outlawed such a system.
- ***All departments and systems are to orient themselves to support the PCP/Case manager/patient/family partnership.***
- All specialty departments are to spend part of their time and energy building and expanding the PCP team capability.
- All specialty departments are to creatively explore effective ways to create relationship with the PCP team.
- ***Departments have entered into 'Service Agreements'***. Service agreements define what each department will do and how they will relate to the other departments. For example Pediatrics and the Urgent Care Center have a service agreement that defines the role of each with children, how they will pass patients between themselves, how they will standardize and coordinate care, etc. These are now in place for the most part.
- Nursing has developed its shared governance structures and processes. The nursing councils and associated activities are assuring integration and standardization of nursing activities across the campus.
- Community education redesign to pull together 'islands' of previous I.H.S. programs.

13. HR processes redesign

- Over the past several years every job description and every performance evaluation was rewritten to be in alignment with SCF mission and key points.

- SCF is now well along the road of revamping the entire corporate system of personnel management. This will include further standardization of job categories and pay. It will include the implementation of an incentive pay system. It will include a redesigned performance evaluation system that is more objective and will require ongoing, continual management feedback to staff.

14. Aligned incentives throughout the system

- The SCF system of same day access to the same PCP will work best for staff if they:
  - Help patients and family do more self care. So patient education and involvement is directly and tangibly rewarded.
  - Work as a team. Any physician who insists on doing everything themselves is going to suffer terribly in this system.
  - Phone management is rewarded. Saves the patient and the physician time.
  - Increased PCP knowledge and capability is rewarded. Specialists get direct benefit from working at this.
  - Every visit builds on the previous one.
  - Max-packing is rewarded – doing everything you can in this visit (prevents future visits decreasing the number of times the patient has to come in and the number of appointments in any given day for providers).
  - Effective, pro-active case management is rewarded. Patients who are better controlled medically are healthier and come in less. Quality of life improves for patients and staff.
  - Prevention is rewarded. Illnesses prevented are patients needing less medical care.
  - Underlying root cause issues are addressed. Since every visit builds on previous ones trust is developed and there is time to address issues of depression, substance abuse, violence, obesity, lack of exercise, etc. In the short run utilization may increase, but over time it should decrease and health should be more likely to increase.
- The system encourages and rewards the above actions directly in more manageable and satisfying professional lives. The feeling of treading water or constantly fighting a non-ending onslaught of patient demand goes away. The feeling of real progress is achievable.
- Specialty departments are rewarded by supporting the PCP system of care. Their work becomes more manageable and rewarding.
- The nursing self-governance process builds on and rewards participatory processes throughout the system. It also standardizes processes across the campus.

15. Central Budgeting and Planning

- SCF requires every department to sell their requests for increases in language that describes how it would help the entire system of care.
- There is effort to have all departments provide comment on the entire list of proposals.
- All revenues go into a central fund and enhancements are mission driven, not revenue generation driven.

- Planning efforts are around a system of care and defined corporate priorities drawn from the mission and key points.
- All division and department goals are aligned with Board approved corporate goals.

16. Intentional Planned processes

- The systems we inherited from I.H.S. were the way they were mostly because of personal passions, effective lobbying, and responses to crisis. In other words, mostly an accident of history.
- ***We have mandated a system of care – intentional, planned systems developed in response to customer needs and wants. Things will be the way they are because we intended them to be that way.***
- ***We prioritize knowing what our customers want and looking far and wide for proven systems that can deliver on those priorities.***
- What we are creating is our own customized integration of best ideas and best practices from all over healthcare. We have taken the systems that address our customers needs and wants and modified them to meet our local needs and realities.
- All lobbying by departments for more funding must be justified by how it supports the system and furthers the mission and goals of our whole system.
- Budgeting, allocation of time and energy, and attention of senior leadership must be driven by intentional, planned priorities and plans.

17. Alignment of Processes

- No individual or department can create their own reality
- See the list of ways the system aligns priorities for PCP's and rewards them for this alignment.
- See list of ways departments are being integrated and creating intentional, written Service Agreements.

18. Improvements in Clinical Quality

- Creating an intentional system of care allows the possibility of coordinated approach to many areas. One area of national attention at present is increasing medical quality by simplifying and standardizing processes. Through this effort decreased medical errors should occur and patient safety should increase. At the same time patients will be getting more consistent input and best practices should be spread more quickly.
- The nursing councils have gone a long ways towards operationalizing this in their areas of influence.
- SCF has a physician working full time (temporarily) on clinical protocol development in order to disseminate best practices and standardize practice to extent it makes sense to do so.
- We are putting in place an intentional, planned approach to coordinating improvement activities of all sorts.

19. Facilities

- SCF proactively made the ANMC campus work by creating the PCC (Primary Care Center) three years ago.
- SCF planned from 4 years ago the expansion of the PCC.
- SCF is rapidly designing and building the PCC to handle at least the next 10 years of volume
- Considerable work on evaluating and developing off campus capacity for many different programs.
- Within the past 12 months and the next 12 months SCF will additionally be providing new or improved facilities for:
  - Dena-A-Coy (nationally recognized residential treatment program for substance abusing pregnant women)
  - Early Headstart program
  - the Pathway Home (a whole system of various levels of care for troubled youth – still in development and recruitment of funding)
  - Our Mountain View satellite clinic,
  - Nutaqsiivik (nationally recognized innovative system of intensive case management for socially highest risk families with newborns)
  - Pacific Home Health - our other home based services including Personal Care
  - our health promotion and research program,
  - Quyana Clubhouse (for the chronically mentally ill)and
  - Our large collection of Behavioral Health programs.

20. Effective Budgeting for the long term

- Creating sinking funds for equipment and capital costs should allow the system to remain equipped and housed without crisis intervention long term.
- Creating and solidifying components of the system in sustainable ways.

21. Long term thinking and planning

- Planning facilities for the long term future
- Creating financial tools that allow sustainability
- Strong attention to funding sources and sustainable funding
- ***Creation of the Primary Care System was in a forward thinking mode that is creating a system that should be sustainable for the long-term*** – even if budgets flatten and population increases. Is a much, much more effective and efficient system of care and allows us the possibility of providing care to more individuals over time within available resources. Lots of rework and redundancy are removed.
- ***This new primary care system builds clinically for the long-term as well.*** Every primary care visit builds on the previous. Every effort is compounded in positive ways to not just treat acute illness, but to better manage chronic illness, prevent illness, and create the environment for promoting wellness. Actually getting to the underlying root causes of illness (lifestyle decisions, depression, violence, etc) is possible. The rewards of good illness prevention and improved wellness are paid back to the system over decades and lifetimes. In a system such as ours where clients, families and communities use the same system for generations, the system actually gets these

paybacks structurally and financially***. It structurally and financially encourages illness prevention and wellness promotion. All health programs and structures should be like this if illness prevention and health promotion are really to be supported by the healthcare system and healthcare cost are to be controlled..***

22. Creation of a rural ASU system of care

- Support of the $5.5m expansion of rural ASU programs
- Programmatic and technical support to village systems.
- Definition of current system and customer satisfaction with system through the Craciun survey.
- Development of an effective, structured method by which SCF and the healthcare system can hear and support the voice of village leadership as the independent voice of the rural Anchorage Service Unit.
- Much attention has paid to improving the relationship of SCF to rural ASU groups. Tremendous headway has been made.

23. Continuum of Care

- Examples of SCF efforts:
  1. Purchase of Home Health Agency
  2. Developed Personal Care Attendant program
  3. Development underway for Hospice and Respite services.
  4. Development of Traditional Healing program
  5. Addition of (limited) Chiropractor services
  6. (Limited) Acupuncture and Biofeedback services
  7. Expansion of Community Education efforts
  8. ***Development of adolescent treatment system – Pathway Home***
  9. ***Development of adolescent work experiences – summer and winter intern programs (impressive SCF initiative to bridge youth into the work environment and the consideration of choosing work in the healthcare environment – with particular emphasis on at-risk youth).***

24. Development of financial stability, partnerships, and other sources of funding

- Continual attention to Federal congressional relationships and continual documentation of needs provided to them to support funding requests.
- Astute attention to I.H.S. systems of expanding and solidifying funding.
- Attention to competing for all I.H.S. funding sources.
- Partnering with city, state, and other partners to extend our funding. Examples:
  1. Mountain View Clinic partnership with ANHC (community health center)
  2. Community Mental Health Center grant
  3. Valley contracts
  4. Dena-A-Coy partnerships
  5. Pathway home alliances
- Pursuing research and clinical improvement grants:

1. CDC Breast and Cervical Cancer Prevention Initiative
2. Cardiovascular Risk Reduction research
3. Komen Foundation funding
4. Run For Women funding
5. NIH exploratory grants
6. Many, many other corporate based grants.

IV. Remaining needs and SCF plans to meet them

1. Adolescent programming

Teens are at the top of many disturbing health trends. These include violence of many sorts, substance abuse, suicide, depression, alcohol abuse, inhalant abuse, etc, etc. Alaska Native youth top all lists for many reasons. Some of them have to do with the transitions from village to urban life, from the lack of clear future possibilities, from a loss of identity as a Native youth, and much more.

SCF Plans:

- The Pathway Home program – this is a comprehensive system of programs from residential treatment for high risk and medium risk youth and outpatient treatment for lower risk youth. The program will include therapy, job training, completion of high school education, and employment skills.
- Intern Trainee program – SCF has already developed this program and has had several hundred youth in it. This program exposes Native youth to the healthcare environment and the world of work in a controlled, intentional way. It helps bridge from school to work and assists youth in completing high school and moving on to further education and training.

3. Home Health Care

Indian Health Service has not provided home based services. We have quite a number of persons for whom receiving care in their home would be very advantageous. Getting the right care to those confined to their homes provides better outcomes and better patient satisfaction while decreasing hospitalizations and overall cost. The VA did a very large project where they provided intensive home based services and lowered overall health system costs to one-sixth of the cost! The ANMC hospital facility is full most of the time and the system has limited funding. It would appear that our system would benefit greatly from expanded home based care.

SCF Plans:

- We have acquired a home health agency. We are seeking funding to expand the system to the point it can be an effective addition to the healthcare system.

2. Hospice

Helping patients spend their last months with family in the setting and the way they choose is a strong Native cultural priority. I.H.S. provided for no hospice care. It is unforgivable the Native patients and families are not provided this important option. There is also

impressive research data to show that effectively run Hospice programs can decrease costs in the last year of life to one fourth of what is the usual amount spent!
SCF Plans:

- SCF is exploring what is required to provide certified, capable hospice care. We are actively pursuing all funding sources we can to try to provide this important service.

2. Mental Health Services

As our greatly improved primary care services work at getting to the underlying issues of illness and wellness, we uncover a great deal of mental health issues. It is imperative that we be able to provide the extent of mental health support to our primary care system.
SCF Plans:

- Expand mental health services as we are able.

5. Health Information Management

Our system is structured around putting health information into the hands of our clients and helping them make decisions about their health issues.
SCF Plans:

- Create a Patient Resource Center. We are working with consultants to create systems of health information for clients and staff that put the appropriate information in their hands when and where they need it.
- Create a comprehensive system of information management for our clients. We are designing a system where the information desk staff, the receptionist staff, the health information staff, and other support staff are part of an intentionally designed system of information management to help our clients find what they need in services and information.
- Integrate health information management, our community education system, our nutritionists, our patient advocates, and our social workers into a coordinated system of support that works efficiently and effectively for our clients.

4. Head Start Expansion

Getting young children off on the right foot early in life is critical. As Native families move to the urban setting, getting early educational skills is a challenge for many. We run a limited Head Start program that could be expanded to many, many times its current size in order to meet the need.
SCF Plans:

- Open Early Head Start program – just opened by SCF, but limited in size.
- Expand Head Start – a high priority.

3. Complimentary and Alternative Health Services

Just as in the rest of the country, our clients have considerable interest in health services that aren't usually part of the allopathic medical system.

SCF Plans:

- We are stepping into this carefully and cautiously. We are providing very limited acupuncture and chiropractor services. We would like to expand both of these services and add massage therapy. We have no plans to expand beyond that at present.

V. Role of Indian Healthcare Improvement Act

We at SCF took an active role in the rewriting of the Reauthorization Act. We worked with other Native leadership from Alaska and across the nation to assure that this document accurately reflects the priorities and needs of our health systems. We believe that the result is a much-improved document that sets the stage for a much better, comprehensive, and well thought our system of care for Alaska Natives and American Indians.

The unfortunate issue is that, while the Act lays out a tremendous vision of what is possible, funding for pursuing this vision remains far, far under what is needed to even begin to meet the goals of the system. It is only right and fair that the first peoples of this proud country get the services they are entitled to as a result of many, many government to government agreements over the years.

We at SCF and ANMC, and many other locations across Indian Country, have demonstrated that we have the expertise and the motivation to provide outstanding services with inadequate funding. We ask that the Improvement Act be passed as we have presented it and that adequate funding be provided to implement it and give us a reasonable chance of bringing the health indicators in Indian Country to at least the level of the rest of the country. It is only right and only fair. We are capable of great things. We have proven it.